SAFETY FIRST IN THE CARE OF DRUGS

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Who has not picked up the daily newspaper and read in glaring headlines the account of the death of some little child who was poisoned by its own hand, or by the hand of a loving parent? How many times the fatal dose of acid has been given for castor oil! And how many times has the mother succeeded in quieting her baby's cry forever by that dose of harmless (?) soothing syrup!

Only those who have gone through these experiences can realize the anguish of heart that carelessness with drugs has caused.

While regard for the laws of health, and proper living reduce the number of drugs needed, yet in the modern home a simple supply of antiseptics, disinfectants, gargles and cathartics will be found on some shelf, or in a less secure place. It is always advisable to have a medicine chest in the home, no matter how simple or inexpensive it may be, and it should be supplied with a lock and key, especially where there are little ones.

Most children are fond of certain preparations of drugs whose taste is disguised with chocolate or some other means. Not infrequently has the mere baby climbed a chair, and taken down some of the "good medicine." He well knows where his mother has placed the bottle. Triturates and tablets are prepared in such a way as to resemble candy, and often the little one will lose no time in helping himself to a generous number, which may produce violent symptoms, or even death.

Not long since, a little boy, who a few hours previous was the picture of health, was taken suddenly very ill. Violent symptoms were at once manifested and it was soon discovered that he had taken a large number of tablets from the cupboard shelf. These he obtained by climbing onto a chair placed near the cupboard. Some fifteen or seventeen tablets were vomited. Medical aid was secured as soon as possible, but even that proved too late to save the child. This sad accident illustrates the necessity for locking all such preparations away from children. All poisons should be kept in a separate place from other medicine and should be plainly labeled as such.

A rather serious, though not fatal accident came about in the following way. A quart jar of blueing containing the poisonous copper sulphate was left on a kitchen cabinet. A member of the family came into the kitchen and mistaking the blueing for grape juice, poured out

a half glass and took several swallows, before he noticed his mistake. Emetics were administered immediately and the patient recovered, but not without a great deal of anxiety.

It is imperative that each bottle in the medicine chest should be properly labeled, and all unknown preparations discarded. The careless labeling of bottles recently caused an accident. Two bottles exactly alike and dark in color stood side by side. One contained 50 per cent alcohol, and the other lysol. Both bottles had previously been labeled but for some cause these labels were missing. A nurse in the act of giving her patient an alcohol rub, took down what she supposed was the alcohol bottle, poured some of the contents into her hand, and applied it to the patient's back before she noticed that she was using lysol instead of alcohol. A large area of the back was blistered.

Another very grave accident came about by the careless preparation of an enema. While a pupil nurse was giving her patient the morning treatment, she stepped to the medicine closet for some turpentine which she needed in making up the enema she was about to give. She measured out the correct amount and while her hands were thus occupied, she was laughing and conversing with a second nurse who came to the medicine closet. Shortly after the injection had been given, the patient was thrown into convulsions. As it was in the forenoon, when the surgeons were making their usual round, one was summoned immediately and when investigation was made, it was found that formaldehyde had been used instead of turpentine. All effort to save the life failed and the patient soon died. In the medicine closet the formaldehyde and turpentine bottles were just alike, but both were plainly labeled, so the mistake was due to the nurse's mind being occupied by other things than her duty.

We cannot be too careful! The testimonies of hundreds who have learned the sad lesson too late should be a warning to each of us who take the responsibility of caring for the sick.